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1.0 Description of the Procedure

Bone mass measurement (BMM) (previously bone mineral density testing) is a radiologic procedure performed for the purpose of quantifying bone mass, measuring changes in bone mass over time, or assessing bone quality. BMM can be used to establish the diagnosis of osteoporosis, to assess an individual's risk of fracture, or to determine the efficacy of osteoporosis drug therapy.

According to the National Osteoporosis Foundation, osteoporosis is a "debilitating disease that can be prevented and treated." It is a "disease in which bones become fragile and more likely to break." Any bone can be affected, but osteoporosis of the hip, spine, and wrist are of special concern, as fractures at these sites can be associated with significant morbidity and mortality.

While BMM can be performed using a variety of systems approved by the Food and Drug Administration (FDA), only Dual-energy X-ray Absorptiometry (DXA) of the axial skeleton (hip, spine) or wrist can be used to diagnose osteoporosis based on WHO T-score criteria. Accordingly, the only BMM test that Medicaid covers for the initial measurement is *CPT code 77080, Dual energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g. hips, pelvis, spine).* If either the spine or hip is not evaluable, use 33% radius (sometimes called one-third radius) of the non-dominant forearm for diagnosis using central DXA (77080).

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.

b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers BMM when it is medically necessary and

a. the procedure is individualized, specific, and not in excess of the recipient's needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medicaid covers BMM when it is medically necessary and

a. the procedure is ordered by a qualified physician or non-physician practitioner who is treating the recipient as defined in 42 CFR § 440.30;
b. the procedure is performed under the appropriate level of supervision as defined in 42 CFR § 440.30; and
c. the procedure is performed with a DXA system (77080) that has been cleared by the FDA as required by 42 CFR § 410.31(a)(2).

Medicaid covers BMM when the medical record documents that the recipient meets the medical indications for at least one of the categories listed below.

a. A female recipient determined to be estrogen deficient and at clinical risk for osteoporosis based on medical history and other findings
b. A recipient with vertebral abnormalities, as demonstrated by an X-ray, that are indicative of osteoporosis, osteopenia, or vertebral fracture
c. A recipient at risk of osteoporosis due to long-term medication:
    1. Long-term (anticipated or actual) glucocorticoid therapy equivalent to 5.0 mg of prednisone, or greater, per day, for three months or greater
    2. Long-term or excess thyroid replacement therapy with evidence for hyperthyroidism
    3. Long-term anti-convulsant therapy for three months or greater
    4. Long-term heparin therapy for one month or greater
    5. Long-term Depo-Provera therapy (for two years or greater)
d. A recipient with primary hyperparathyroidism
e. A recipient being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy
f. A recipient with a history of low trauma fracture
g. A female recipient 65 years of age or older
h. A male recipient 70 years of age or older
i. A recipient with other conditions, or on medical therapies, known to cause low bone mass

3.3 Osteoporosis Drug Therapy Monitoring

The only BMM test that Medicaid covers for the monitoring of osteoporosis drug therapy is *CPT code 77080, Dual energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g. hips, pelvis, spine).*

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows

how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

BMM is not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure; or
d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Medicaid does not cover BMM for the following procedures as they are not considered reasonable and necessary under Social Security Act section 1862(a)(1)(A).

CPT Code	Description
77078	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g. hips, pelvis, spine)
77079	Computed tomography, bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel)
77081	Dual energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel)
77082	Dual energy X-ray absorptiometry (DXA), bone density study, one or more sites; vertebral fracture assessment
77083	Radiographic absorptiometry (e.g. photodensitometry, radiogrammetry), one or more sites
78350	Bone density (bone mineral content) study, one or more sites; single photon absorptiometry
78351	Bone density (bone mineral content) study, one or more sites; dual photon absorptiometry, one or more sites
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is not required.

5.2 Limitations

a. BMM is limited to one test every two years for individuals at risk for low bone mass (at least 23 months must have passed since the month the last covered BMM was performed).

b. An additional BMM may be covered more frequently than every 23 months for the following conditions:

1. Long-term glucocorticoid therapy of 5.0 mg of prednisone or more per day of more than three months' duration
2. Long-term anticonvulsant therapy of more than three months' duration
3. Monitoring with uncorrected primary hyperparathyroidism

6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for BMM when the BMM is within the scope of their practice.

7.0 Additional Requirements

7.1 Federal and State Requirements

All providers are required to comply with all applicable federal and state laws and regulations.

7.2 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.3 Baseline DXA Report

The minimum requirements recommended by The International Society for Clinical Densitometry (ISCD) include (but are not limited to) the following:

a. Demographics of the recipient, including name, medical record identifying number, date of birth, and sex

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b. Requesting provider
c. Indications for the test
d. Manufacturer and model of instrument used
e. Technical quality and limitations of the study, if any
f. The skeletal sites and region of interest (and, if appropriate, the side) that were scanned
g. Physician's interpretation of the results, including a statement about fracture risk
h. Recommendations for the necessity and timing of the next DXA study

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1987

Revision Information:

Date	Section Revised	Change

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Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

The following primary diagnosis codes permit BMM to be performed more often than every 23 months.

ICD-9-CM Diagnosis Code	Description
V58.65	Long-term (current) use of steroids
V58.69*	Long-term (current) use of other medications
252.01	Primary hyperparathyroidism

*Use for anticonvulsant therapy of more than three months' duration. Bill with secondary diagnosis for epilepsy, 345.00 through 345.91, or other convulsions, 780.39.

C. Procedure Code(s)

CPT Code	Description
77080	Dual energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg hips, pelvis, spine)

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient, outpatient, physician's office, patient's home, intermediate care facility, skilled nursing facility

F. Co-Payments

Procedure codes listed above are not subject to co-payment.

G. Reimbursement

Providers must bill their usual and customary charges.